Medical History

Today's date_____

Name _____ Date of Birth _____

Past Medical History and Review of Systems

Please check off if you have had any problems with or are presently experiencing any of the following:

- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Chest Pain/chest tightness
- ☐ Shortness of breath
- ☐ Swollen ankles
- ☐ Palpitations
- ☐ Lightheadedness
- ☐ Frequent urination
- ☐ Rheumatic fever
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Persistent cough
- ☐ T.B.
- ☐ Hay fever
- ☐ Abdominal discomfort
- ☐ Indigestion
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in stool
- ☐ Ulcers
- ☐ Change in bowel habits
- ☐ Unexplained weight loss/gain
- ☐ Hemorrhoids
- ☐ Gall Bladder disease
- ☐ Colitis
- ☐ Hepatitis or jaundice
- ☐ Thyroid disease
- ☐ Head or neck radiation
- ☐ Headache
- ☐ Kidney disease
- ☐ Difficulty urinating
- ☐ Arthritis
- ☐ Low back problem
- ☐ Skin disease
- ☐ Blood disorders
- ☐ Pelvic pain
- ☐ Venereal disease
- ☐ Anxiety
- ☐ Depression
- ☐ Anemia
- ☐ Gout
- ☐ Drug Abuse
- ☐ Alcohol Abuse
- ☐ Impotence or Erectile Dysfunction
- ☐ Other

Surgeries: Please list any surgeries you have had:

_____ _ _____

_____ _____

_____ _____

Prevention

Do you wear seat belts? ___ Yes ___ No
Do you wear a bike helmet? ___ Yes ___ No
Do you exercise regularly ___ Yes ___ No If yes, how often _____
Do you caffeinate beverage ___ Yes ___ No If yes, how many cups per day _____
Are you in a relationship in which you have been physical hurt? ____ Yes ____No
Do you ever feel afraid at home? ____ Yes ____No
Do you have a "Living Will" ____ Yes ____ No
Do you have a "Donor Card"? ____ Yes ____No
Do you smoke? ____Yes ____ No, if yes how often _____
Have you ever smoked? ____ Yes ____ No Year stopped _____
Other tobacco use _____
Do you drink Alcoholic beverages? ____Yes ____No If yes, how often? _____
Do you use drugs? (marijuana, cocaine etc.) ____ Yes ____No If yes, please explain _____

Name :_____ Date of Birth_____

Allergies to Medication, X-Ray Dyes, or other Substance _____Yes ____No
(if yes, please list what you are allergic to and reaction)

_____ _____
_____ _____
_____ _____
_____ _____

Family History: Has any member of your family (including parents, grandparents, siblings) ever had the following? Please Circle

Cancer	_____ Yes	_____ No	Mother	Father	Grandmother	Grandfather	Sibling
Hypertension	_____ Yes	_____ No	Mother	Father	Grandmother	Grandfather	Sibling
Heart Disease	_____ Yes	_____ No	Mother	Father	Grandmother	Grandfather	Sibling
Diabetes	_____ Yes	_____ No	Mother	Father	Grandmother	Grandfather	Sibling
Strokes	_____ Yes	_____ No	Mother	Father	Grandmother	Grandfather	Sibling
Glaucoma	_____ Yes	_____ No	Mother	Father	Grandmother	Grandfather	Sibling
Mental Disorders	_____ Yes	_____ No	Mother	Father	Grandmother	Grandfather	Sibling
Anxiety	_____ Yes	_____ No	Mother	Father	Grandmother	Grandfather	Sibling
Depression	_____ Yes	_____ No	Mother	Father	Grandmother	Grandfather	Sibling
Drug Addiction	_____ Yes	_____ No	Mother	Father	Grandmother	Grandfather	Sibling
Alcohol Addiction	_____ Yes	_____ No	Mother	Father	Grandmother	Grandfather	Sibling
Bleeding Disorders	_____ Yes	_____ No	Mother	Father	Grandmother	Grandfather	Sibling

Other _____

FOR NEW PATIENTS ONLY:

Please list all medications (prescription, Over the counter, Vitamins, Herb, etc.)

Name of Drug	Dosage	Name of Drug	Dosage
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____